

FEDERAL BUREAU OF PRISONS
CLINICAL PRACTICE GUIDELINES FOR PSYCHIATRIC EVALUATIONS
March, 2002

PURPOSE

The Federal Bureau of Prisons Clinical Practice Guidelines for Psychiatric Evaluations provide recommendations for psychiatric assessment of federal inmates. This guideline does not address forensic assessments or other court ordered evaluations.

REFERENCES

1. American Psychiatric Association: Practice Guidelines for the Treatment of Psychiatric Disorders, Compendium 2000, pp 1-29.
2. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (Text Revision), DSM-IV-TR, 2000.
3. Kaplan and Sadock; Comprehensive Textbook of Psychiatry, Seventh Edition, 2000, pp 652-689.

DEFINITIONS

Assessment is otherwise termed evaluation, and is the process of evaluating an inmate for the presence of a mental illness or disorder, utilizing the diagnostic format and categories in DSM-IV-TR and generally includes an interview with the inmate, behavioral observations, review of the medical record, review of the Central File, especially the presentence investigation report, review of outside records and utilizing information gathered from staff and other sources. Although psychiatric assessment is a dynamic process that in reality occurs over time, for the purposes of these guidelines implies the part of the evaluation process that takes place in the time frame immediately surrounding the psychiatrist's initial clinical contact with the inmate.

Axis: An axis is a domain of information as developed and delineated in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revised (DSM-IV-TR), designed to aid the clinician in planning treatment and predicting outcome. The axes are divided into five domains as follows:

Axis I: All mental disorders except Mental Retardation and Personality disorders are reported on this axis.

Axis II: Diagnoses of Mental Retardation and Personality Disorders are reported on this axis. Also personality traits of sufficient degree to cause distress or some impairment but not of a severity to meet the full criteria for a personality disorder are reported on Axis II.

Axis III: This domain is for recording the presence of general medical conditions, especially those which may impact evaluation, treatment or prognosis of the inmate's mental condition.

Axis IV: Psychosocial and Environmental problems that may affect the diagnosis, treatment or prognosis of the inmate's mental disorder are recorded on this axis. Incarceration is considered an axis IV condition.

Axis V: This axis is for reporting the inmate's overall level of functioning. Information is recorded using the Global Assessment of Functioning (GAF) Scale found in

DSM-IV-TR. The GAF rating is generally recorded for the current level of functioning, but can also include specific time periods, such as "Best in the past year," or "At discharge."

Evaluation: See "Assessment"

Mental Illnesses is the group of all diagnosable mental disorders. The presence of active mental illness implies that there is a significant functional disturbance in any of the following areas: intellectual, emotional, behavioral, social, relational, occupational, or educational.

Mental Disorder is a medical condition that causes a disturbance of mood, behavior or thinking, such that there is significant impairment in functioning, or significant distress or disability.

Mental Health Treatment is any intervention for an inmate suffering from a mental disorder or illness aimed at improving the inmate's functioning. Treatment can include medication, various forms of therapy and housing in a hospital unit with a therapeutic milieu, among others.

Psychiatric Consultation is an assessment that has been prompted by a physician or other clinician, generally other than a mental health professional, because of the possibility that the inmate being referred is suffering from a mental disorder or illness that is causing significant distress, disability or behavioral abnormality. The scope of the referring question is generally limited and thus a more abbreviated evaluation process may be acceptable. On mental health inpatient units where a psychologist is the primary clinician, **and** the medical condition of the inmate is being managed **completely** by non-psychiatric health services staff, as is occasionally found in some forensic settings, the psychiatrist may act as a consultant to the psychologist. In those cases, and in the case of providing a second opinion to another mental health professional who has already completed a full evaluation, a psychiatric consultation, as opposed to the more comprehensive psychiatric evaluation, may be appropriate.

The psychiatric consultation should not be construed to mean the assessment of an inmate referred by the health services unit or psychology staff of a mainline institution for evaluation and probable ongoing psychiatric treatment. In

cases where an inmate is referred to the chronic care mental health clinic for assessment, the psychiatric evaluation should be comprehensive.

Psychiatric Emergency is synonymous with "mental health emergency," and includes any situation in which an inmate with a probable mental disorder or illness is at imminent risk of harm to self or others, or at imminent risk of serious disruption of the therapeutic milieu that places the inmate at risk of harm by others, or at imminent risk of serious destruction of property which would immediately endanger the safety of staff, inmates or others.

INTRODUCTION

The psychiatric evaluation should fulfill the following purposes:

1. Establish a psychiatric diagnosis
2. Evaluate and determine the extent to which the inmate's problem interferes with his/her normal functioning and/or the safe and secure functioning of the institution
3. Serve as a data base upon which a treatment strategy can be formulated and founded
4. Serve as a form of communication between health care providers now and in the future

The standardization of the general content and documentation of psychiatric evaluations also serves several purposes:

1. Improves the quality of health care
2. Provides a consistent data base for ongoing evaluation and treatment of inmates regardless of their movement between institutions
3. Improves patient continuity of care

An emphasis on any particular element(s) of the assessment will vary depending on many factors, including: the reason for the evaluation, the site of the evaluation, the urgency of the evaluation, the condition of the inmate, and the time available for the evaluation. The initial evaluation will not contain all the data eventually gathered on any particular patient, as psychiatric assessment is a process rather than an event. Therefore, readers of the medical record must assume that additional relevant information will be contained in

progress notes and discharge summaries, not just the initial evaluation.

Psychiatric assessments can be general evaluations, emergency evaluations or clinical consultations (n.b., forensic evaluations are not covered in this discussion). The general principles of psychiatric assessment apply to all three of these evaluations, however some differences are notable.

Initial general psychiatric evaluations focus on establishing rapport with the inmate, gathering as much data as possible to establish accurate diagnoses, formulation of a treatment plan, education of the inmate, ensuring inmate and staff safety and identifying those problems, both psychiatric and medical, needing further evaluation. Awareness of cultural, ethnic and gender specific issues is necessary for optimizing the interview and treatment processes of the inmate.

Emergency psychiatric evaluations generally occur under less than ideal circumstances and are prompted by symptoms that are intolerable to the inmate or staff, and/or present a risk of harm to the inmate or others. The goal of the evaluation is first and foremost to ensure the safety of inmate and staff. This generally requires gathering enough data to establish a working diagnosis with special attention to potential medical conditions contributing to, or arising from, the inmate's psychiatric illness. Attention to environmental factors that may have triggered the emergency is a necessary part of the evaluation. Formulation of short term and longer term treatment plans are an integral part of an emergency intervention. The immediate treatment plan may include the use of seclusion, restraints or other safety measures. An intermediate treatment plan may include pursuing involuntary hospitalization. Long term treatment planning may focus on interventions designed to prevent future psychiatric emergencies.

Psychiatric consultations are theoretically shorter, more focused evaluations. The referral source will generally ask specific questions or request interventions in specific areas of patient care. Inmates referred for psychiatric consultation often have multiple medical and social problems complicating their presentations, and psychiatrists are uniquely qualified to assess and integrate these factors. It is incumbent upon the psychiatrist to address and present these issues in a coherent and cohesive fashion to the

referral source. Clear and thorough documentation greatly improves communication with other health care providers and serves as an excellent source of information and education for colleagues.

PROCEDURES

The Evaluation Process

- **Indications:** Psychiatric evaluations may be prompted by any the following circumstances:

1. A mental health emergency exists
2. An inmate has a history of mental illness or disorder, or a history of self-harm behaviors
3. An inmate is on psychotropic medications that warrants review
4. An inmate requests a psychiatric evaluation
5. Referral from psychology or a health care provider
6. A court request
7. An inmate exhibits a change in mental status or has new or recurrent onset of other symptoms of a possible mental disorder
8. An inmate's behavior has become disruptive to the institution

- **Psychiatric evaluations:** Initial psychiatric evaluations should generally include the information outlined in **Appendix 1, Standards for Psychiatric Evaluations**, and should be formatted as outlined in **Appendix 2, Format for Psychiatric Evaluations**.

- **Psychiatric consultations:** Psychiatric consultations should generally include the information outlined in **Appendix 3, Standards for Psychiatric Consultations** and should be formatted as outlined in **Appendix 4, Format for Psychiatric Consultations**.

- **Emergency consultations:** The standards and format for emergency psychiatric evaluations are essentially identical to those of a routine psychiatric consultation, however, because of the urgency of the evaluation certain data may not be gathered. Despite the limitations of time, the assessment must be comprehensive enough to support the working diagnosis

and treatment plan.

- Acquiring clinical data: A substantial portion of the data necessary for formulating psychiatric diagnoses and treatment plans comes from face to face interaction with the inmate. The interview process includes a combination of behavioral observations, open-ended questions, closed-ended questions and usually a formal mental status examination.

Although assessment relies heavily on the information gathered during the interview, it also relies on collaborative data, including:

1. Review of the medical record,
2. Information in the central file, including disciplinary reports and the presentence investigation,
3. The observations of others, and
4. Outside medical and psychiatric records.

The relative weight given to any of these other sources of data will depend upon the presentation of the inmate and the urgency of the situation. In all cases where a medical record exists, assessment will include a review of the medical record.

- Evaluation time frames: The time frame for completing the initial evaluation will vary depending on the nature of the evaluation, the housing status of the inmate as well as other circumstances. Initial evaluations typically require at least 60 to 90 minutes to complete, however, shorter or longer evaluations may be appropriate depending on the complexity of the patient. If there are substantial records to review, this will extend the time frame required to complete the evaluation. For inmates housed on an inpatient mental health unit, the initial evaluation is generally completed within 24 hours of admission to the unit, or the first working day following admission. For inmates housed in the general population or on outpatient psychiatric units, the time frame may vary from a few hours to a few weeks, depending on the urgency of the inmate's symptoms and behavior. Emergency evaluations are generally completed within minutes to hours of the referral. For consultations, the psychiatrist will address the urgency of the referral question(s) with the referral source and determine an appropriate time frame in which to complete the evaluation.

- **Follow-up investigation:** Following the initial interview, the psychiatrist may determine the need for further evaluations that may include:

1. Further psychiatric interviews
2. Medical or neurological evaluations
3. Radiologic studies
4. Laboratory studies
5. Psychological testing, and/or
6. Collaborative interviews with family or others (following appropriate procedures for release of information).

Documentation

The psychiatric evaluation is documented in the inmate's medical record. For reasons of legibility, a dictated, typed report is preferred; however, a complete hand written assessment is also acceptable. The documented assessment becomes an important source of information for future providers, psychiatric and non-psychiatric, and therefore the source of the information in the evaluation should always be noted. Documentation of the active symptoms serves as an important reference for future episodes of illness, since each episode often follows a similar course.

At times there may be a complete or near complete psychiatric evaluation already documented in the medical record. Much of the data in that report may not have changed. Therefore repetition of all of the data contained in that evaluation is not necessary. A summary of relevant data under each heading and/or a specific referral to the previous evaluation by the title of the note and the date of the note is sufficient, e.g. "ALCOHOL HISTORY: No change from Inpatient Psychiatric Evaluation, dated 1/1/99." The interview should include a review of the previously documented information. Any changes or contradictions can be noted under the appropriate heading.

During emergency evaluations certain clinical data may not be gathered due to the urgency to provide treatment. Relevant uncollected data should be documented as such in the medical record, e.g., "ALCOHOL HISTORY: Not gathered at this time."

When information exists in documents other than the BOP medical record, e.g. outside medical records or the central file, it is preferable to summarize the information and include that summary under the appropriate headings in the

evaluation.

Due to the very high rate of comorbidity of medical and psychiatric disorders, documentation should include relevant positive **and** negative findings. Special emphasis on safety of the inmate and others is included in the assessment and the documentation. Therefore it is not sufficient to observe in the interview that the inmate denies any passive or active thoughts, plan or intent to harm self or others. This relevant negative finding must be thoroughly documented in the record as well. Any positive findings around safety issues require further exploration and full evaluation and documentation.

ATTACHMENTS

Appendix 1 - Standards for Psychiatric Evaluations

Appendix 2 - Format for Psychiatric Evaluations

Appendix 3 - Standards for Psychiatric Consultations

Appendix 4 - Format for Psychiatric Consultations

STANDARDS FOR PSYCHIATRIC EVALUATIONS

(Label as INPATIENT or OUTPATIENT)

- I. IDENTIFYING DATA:** This will include: age, sex, race/ethnicity, country of origin, marital and parental status, residence, designation, charges, sentence, parent institution, source of information, legal status-including voluntary vs. involuntary hospitalization. If known, add expected release date and/or when sentence began.
- II. CHIEF COMPLAINT:** This is a succinct statement, often in quotes, of the inmate's perception of the purpose of the evaluation. If the inmate is referred by another provider for the evaluation, include the reason for the referral and the referral source.
- III. HISTORY OF PRESENT ILLNESS:** This is a narrative summary of the chief complaint, its duration, intensity, efforts at and results of any treatment, etc. If present illness is recurring, e.g. a recurrent major depression, past treatments and outcomes should be included. This must include discussion of any past or present thoughts or behaviors related to violence towards self or others. In this discussion include precipitating factors for such behaviors, level of violence, use of weapons, outcome of actions. If there is no history of violence towards self or others a statement regarding that is necessary.
- IV. PAST PSYCHIATRIC HISTORY:** Include here any past psychiatric history not included under HPI. This is generally a chronological summary of all past illnesses, syndromes and treatments and treatment outcomes. Once again history of any violence towards self or others, whether or not the inmate was under psychiatric care, is relevant and necessary.
- V. ALCOHOL HISTORY:** This is a brief history of alcohol use including age of first use, type and amount of use, attempts at abstinence, consequences of use - legal or

otherwise, symptoms of abuse, e.g. hangovers, blackouts, withdrawal symptoms, etc. Include treatments and their types, court ordered treatment, insight into use and date of last use.

- VI. DRUG HISTORY:** Same as Alcohol History. Include routes of use for drugs used and last use. Include all types of drugs used, their amounts and patterns of use.
- VII. PAST MEDICAL HISTORY:**
- Surgeries:
 - Hospitalizations:
 - Head Injuries:
 - Fractures:
 - Current Medical Problems:
 - Current Medications: Include all medications:
 - prescribed, psychotropics, over-the-counter, and their doses
 - Allergies:
 - Tobacco:
 - Caffeine:
 - Pregnancy History:

 - Review of Systems:
 - HEENT:
 - Cardiac:
 - Pulmonary:
 - Gastrointestinal:
 - Urinary:
 - Menstrual: LMP:
 - Joint/Skeletal:
 - Skin:
 - Neurologic:
- VIII. FAMILY HISTORY:** This includes medical, psychiatric, and criminal history of blood relatives. Include especially any history of homicides, suicides, or attempts at such.
- IX. SOCIAL HISTORY:** This includes the following: Family of origin, birth order, number and type of siblings, history of any type of abuse, educational history, employment history, marital history, military service, religion, current household, number, sex and ages of children, their current whereabouts, nature of relationships with them, custodial issues, any social service involvement, hobbies and leisure activities, plans after release.

- X. CRIMINAL HISTORY:** Include current charges and all past charges and arrests including juvenile history (running away, shoplifting, truancy, etc). If any convictions, include sentence and time served, when and where. This information is generally available in the presentence investigation report.
- XI. MENTAL STATUS EXAM:** Documentation of the mental status examination should follow a systematic format by which the current presentation of the inmate can be effectively captured and presented. The mental status exam generally includes the following:
- General description of appearance, ability to give history and its judged accuracy
 - Mood and affect
 - Psychomotor activity
 - Form of speech
 - Thought content
 - Presence or absence of suicidal ideation, plan or intent
 - Presence or absence of homicidal ideation, plan or intent
 - Cognitive function and estimate of intellect
 - Level of insight
 - Motivation for treatment
- X. DIAGNOSTIC IMPRESSION:** The diagnoses will follow the five axis format as defined in DSM-IV-TR. Whenever possible the diagnosis pertaining to the reason for the assessment or which will be the focus of treatment should be listed first on its appropriate axis. Other diagnoses may be listed in descending order according to focus of treatment. Subtypes and specifiers as defined in DSM-IV-TR should also be used whenever possible. A narrative summary can supplement the diagnoses as listed on the five axes.
- XI. PLAN:** The treatment plan is ordinarily articulated in a narrative format and includes specifics regarding medications, doses, etc. Include a statement regarding informed consent for treatment. This will include a discussion of the risks and benefits of treatment, alternatives to the proposed treatment, any questions the inmate asked regarding the treatment and your answers, the inmate's level of understanding regarding

the treatment and his/her level of competence to give informed consent. Also include a statement regarding having the inmate sign the informed consent form. Include plans for further psychiatric, psychological or medical evaluations. Consideration of the need for acquisition of outside records and inmate's signed consent for records can be included here. Interventions directed at issues of inmate and staff safety will be delineated here.

For outpatients include the next appointment date, e.g., "The patient will be seen in four weeks and may return sooner should he/she experience worsening of symptoms or significant side effects."

For inpatients include a description of reason or reasons for admission to this more restrictive setting with emphasis on symptoms meeting criteria for inpatient admission. Include the format for the work-up (i.e. all laboratory tests, psychological studies, medical examinations) and specific treatments including individual, group, occupational, activity therapies, etc. When possible include a prognosis and estimated length of stay.

FORMAT FOR PSYCHIATRIC EVALUATIONS

- I. IDENTIFYING DATA
- II. CHIEF COMPLAINT
- III. HISTORY OF PRESENT ILLNESS
- IV. PAST PSYCHIATRIC HISTORY
- V. ALCOHOL HISTORY
- VI. DRUG HISTORY
- VII. PAST MEDICAL HISTORY
- VIII. FAMILY HISTORY
- IX. SOCIAL HISTORY
- X. CRIMINAL HISTORY
- XI. MENTAL STATUS EXAM
- XII. DIAGNOSTIC IMPRESSION
 - Axis I:
 - Axis II:
 - Axis III:
 - Axis IV:
 - Axis V:
- XIII. PLAN

STANDARDS FOR PSYCHIATRIC CONSULTATIONS

The standards for consultation are an abbreviated version of the standards for the Psychiatric Evaluation in Appendix 1. Exceptions are noted below.

I. IDENTIFYING DATA

No change

II. CHIEF COMPLAINT

No change except emphasis on referral question

III. HISTORY OF PRESENT ILLNESS

No change

IV. ALCOHOL HISTORY

No change

V. DRUG HISTORY

No change

VI. PAST MEDICAL HISTORY

Eliminate Surgeries, Hospitalizations, Head Injuries, Fractures, and Review of Systems, except as relevant to current presentation

VII. FAMILY HISTORY

No change

VIII. SOCIAL HISTORY

Usually an abbreviated version of that contained in the Psychiatric Evaluation emphasizing those areas of the social history relevant to the current presentation

IX. MENTAL STATUS EXAM

No change

X. DIAGNOSTIC IMPRESSION

No change

XI. PLAN

This will be essentially unchanged from the standards in the Psychiatric Evaluation but will

place emphasis on addressing and making recommendations regarding the referral question/questions. This may include further studies, evaluations, or specific treatments, including medication, hospitalization or other treatments.

FORMAT FOR PSYCHIATRIC CONSULTATIONS

- I. IDENTIFYING DATA
- II. CHIEF COMPLAINT
- III. HISTORY OF PRESENT ILLNESS
- IV. ALCOHOL HISTORY
- V. DRUG HISTORY
- VI. PAST MEDICAL HISTORY
- VII. FAMILY HISTORY
- VIII. SOCIAL HISTORY
- IX. MENTAL STATUS EXAM
- X. DIAGNOSTIC IMPRESSION
- XI. PLAN